



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: PRIDE 5701 MAPLE AVENUE SUITE #100 DALLAS TX 75235	MFDR Tracking #: M4-11-2248
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In accordance with DWC rule 134.600 (c) (B) and (p) (B) (10) an insurance carrier is liable for all reasonable and necessary medical costs relating to interdisciplinary pain management, functional restoration, physical/occupational therapy and or counseling when it was pre-authorized prior to providing the care. As can be seen from the attachments the medical care in question was preauthorized at the address the care was provided. Texas Mutual Insurance Company (TMIC) and the Texas Star HCN were aware throughout the entire process (and for 2 years prior to the initial denial of benefits) that PRIDE was a non-network provider of rehabilitation services. Unique electronic billing requirement requested by Texas Star HCN were established for PRIDE services in mid-2008, and used continuously from that time forward. At the time all services were pre-authorized. Dr. Larry Johnson, a PRIDE physician independent contractor, was listed as Requesting Provider. For those reasons the carrier is liable for the medical services that are subject of this request for Dispute Resolution."

Amount in Dispute: \$19,926.30

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided pain management services to the claimant from 4/19/2010 through 6/18/2010. This claim is in the Texas Star Network ('Network')... The requestor is not a participating health care provider in that network. The treating doctor is John Diamond, M.D....DWC Rule 134.600(h) states that the carrier shall approve or deny preauthorization requests based *solely* upon the medical necessity of the health care required to treat the injury. ...Review of Texas mutual's claim file shows (1) the requestor's documented treatment does not reflect treatment one would normally consider as emergency care; (2) the claimant lived within the service area of the network; and (3) there is no documentary evidence of a referral by the treating doctor to the requestor for treatment. ...Texas Mutual has no record of any request for a referral from the treating doctor to this out-of-network provider nor has the requestor provided any evidence of such in its DWC-60 packet. Texas Mutual initially paid for code 97799 for prior dates of service before further research revealed there was no treating doctor referral or approval by the Network for these services. Texas Mutual denied all other dates of service for code 97799 as the provider was not approved to treat a Texas Star network patient.

Response Submitted by: Texas Mutual Insurance Company, 6210 East Highway 290, Austin, Texas 78723-1098

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
04/19/2010 thru 06/18/2010	97799 CP-CA	N/A	\$19,926.30	\$0
06/18/2010	A9300	N/A		
Total Due:				\$0

PART V: FINDINGS

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS
 - 907 ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.
 - Cac-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
 - 790 THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
 - Cac-38 SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK/PRIMARY CARE) PROVIDERS
 - 727-PROVIDER NOT APPROVED TO TREAT TEXAS STAR NETWORK CLAIMANT FOR NETWORK INFORMATION

Issue

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Tex. Admin. Code §§133.305 and 133.307?

Findings

1. This dispute was filed at the Texas Department of Insurance, Division of Workers' Compensation (Division), Medical Fee Dispute Resolution section on March 7, 2011 for resolution pursuant to 28 Tex. Admin. Code §133.307.
2. 28 Tex. Admin. Code §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care *not* [emphasis added] delivered, or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules..." 28 Tex. Admin. Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care..." Therefore, pursuant to 28 Tex. Admin. Code §133.305, and §133.307, the Division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.
3. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Health Care*. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307, and medical fee dispute resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division concludes that medical fee dispute is not the appropriate venue for resolution of the issues raised by requestor. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

08/23/11

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.